creased tension, some of the sutures had to be cut within twenty four hours, and healing by granulation took place. From the time of operation the symptoms were invariably promptly relieved. Convalescence was uneventful except in one instance, in which a limited grangrene of the cæcum took place, with fæcal fistula, which spontaneously closed in five months.

The operations were performed at periods varying from the third to the ninth day after the first symptoms had appeared.

The post-operative treatment consisted, in a general way, in keeping the abdominal cavity drained and the bowels acting freely.

Hypodermic injection of morphine was reluctantly used upon two occasions, shortly after the operation, to relieve pain and restlessness.

Milk and broths were freely given, while stimulants and quinine were early required.

GENITO-URINARY ORGANS.

I. Final Results of Four Operations for Vesical Tuberculosis. By PROFESSOR F. GUYON (Paris). At the last Surgical Congress Prof. Guyon read a lengthy paper with the above title, giving his personal results and experience. The cases, which are extremely interesting, are recorded here in brief.

I. Male, æt. 24 years, was operated on by suprapubic cystotomy on July 8, 1885, and had then been suffering for two years with symptoms of vesical tuberculosis. Patient was last seen August 26, 1889. Was married and had one child. Only urinates every two or three hours by day and twice during the night. Has gained flesh and strength.

II. Male. Died two years after the operation. The patient suffered from vesical trouble since September, 1886; his urine contained tubercle bacilli. Epicystotomy was performed April 30, 1887, bladder scraped and tubercular ulcers cauterized, since that time patient has been obliged to remain in bed most of the time and had frequent micturition though there was a vesical fistula which discharged much pus. This condition lasted till his death, which occurred July 22, 1889. Autopsy showed both kidneys diseased. The left was a vast purulent collection, divided into pockets and did not communicate with the ureter

which was obliterated. The right kidney was the seat of marked pyelonephrosis. No tubercles found in kidneys or ureters, only found in the vesiculæ seminales. Bladder extremely small, only holding a few c.c. of fluid. There is a fistula at the seat of the hypogastric incision, walls of the viscus thickened, no granulations or ulcerations.

III. Symptoms of seven months standing, epicystotomy March 17, 1888. Right kidney at that time was diseased, increased in size, tender to the touch. Patient had polyuria since 1887. Patient had to urinate as much as 100 times during night. Notwithstanding the damaged condition of the right kidney the operation was undertaken, and patient improved very much till May, 1888, when the left kidney became tender. The bladder was not painful, but a hypogastric fistula remained.

Patient died of marasmus February 7, 1889. Autopsy showed both kidneys tuberculous, the right completely destroyed and ureter obliterated. A number of tubercular nodules were found under the mucous membrane of the bladder. The mucous membrane was smooth and pink, while at the time of operation it was turgescent and thickened; though it showed no ulceration it was scraped with a sharp curette, burnt and swabbed with iodoform gauze.

IV. Male, æt. 34 years. Perineal cystotomy on December 10, 1884 for marked tubercular cystitis; patient died March 25, 1885. Whole of posterior urethra and bladder showed numerous tubercular ulcerations and granulations.—*Annals des Mal. des Voies Urin.*, November, 1889.

F. C. HUSSON (New York).

II. Case of Scrotal Luxation of the Penis. By Dr. SERGEHI M. MALENOVSKY (Kazan). The author details at length the following curious, interesting, and exceedingly rare case of traumatic injury to the male genitals:

A married peasant, æt. 30 years, while being busy about a working thrashing machine, was caught between a revolving horizontal bar and its straps, and thrown over, the right half of his loose and thick trousers being entangled and tightly stretched, and violently dragging all along the integument of the penis, jammed between the garments and

the thigh. When examined by a Feldsher, (medical assistant) immediately after the accident, the patient was found to have (*a*) a complete circular rupture of the foreskin along the retro glandular sulcus; (*b*) another laceration of the integuments about the scroto-penal fold; and (*c*) displacement of the penis under the scrotal skin. The first and only aid consisted in antiseptic irrigations. In about three weeks the wounds healed, but there remained a hole in the said fold, through which the urine was voided, The man soon discovered that he had become utterly unable to perform coition, the penis failing to emerge from the scrotal hole. Feeling anxious to recover his sexual ability, he sought at last, about four months after the accident, his admission to Prof L. L. Levshin's clinic, where the examination revealed the following state of things: The integuments of the penis were hanging down on the anterior surface of the scrotum in the shape of a flabby and shortened cutaneous tube with an open distal end which formed a cicatricial ring impassable even for a little finger. A probe introduced into the sac struck a cicatricial septum at the depth of 1½-ins. In the scroto-penal fold, just to the left from the raphe, there was present an orifice with cicatrized edges, admitting a little finger. The latter could feel the glans of the penis lying just beyond the hole, in an accessory sac separated from the preputial one by a dense cicatricial partition of from 2 to 4 mm. in thickness. A little deeper the body of the member could be felt, its surface being connected with the scrotal skin but very loosely. When passing water, the patient adjusted the glans to the scrotal hole in a certain manner, the urine escaping in the shape of an arched full-sized jet; when the adjustment was omitted, the urine was seen to at first distend the penal sac and then to flow in an irregular, interrupted stream. On erection the penis remained entirely withing the scrotum. To restore normal relation of the parts, Dr. Malinovsky, following Nelaton's and Demarquay's recommendations, made an attempt at reduction of the penis—that is, at placing the latter into its empty cutaneous tube. The operation consisted in (*a*) a crucial enlargement of the preputial orifice; (*b*) dilatation of the tube cavity by big-sized drainage tubes and tupelo-tents; (*c*) a division of the cicatricial partition; (*d*) dilatation of the incision; (*e*) breaking down the adhesion between

the glans and scrotum; and (*f*) attempts at dragging out the glans from its scrotal cavity into the now prepared cutaneous tube. All these attempts, however, utterly failed, the main obstacle being formed by a dense cicatricial constriction in the upper portion of the restored canal. In view of the failure, a phalloplastic operation was resorted to. Having split up the integumental tube from the preputial opening up to the superior one, as well as the scrotum, the author sewed (*a*) the free preputial edge with the remnants of the foreskin on the glans; (*b*) the edges of the penal integumental incision with the scrotal flaps; and (*c*) the latter, anteriorly and inferiorly with the remnants of the inner layer of the foreskin on the glans. The silk sutures were removed on the sixth and eighth day, the wounds healing *per primam*. The member, formed by the phalloplastics, measured 2·ins. in length (from the glans to the pubes) and, to the patient's greatest delight, proved to be quite effective for all his purposes. About six months later, the patient's father informed the author that his son's penis had markedly increased in length; which is attributed by Dr. Malinovsky to stretching and elongation of cicatricial tissues under the influence of erections and coitions. The author has been able to find only four other instances of luxation of the penis in international literature for the last forty years. They are: 1. Nelaton's case (*Gazette des Hopitaux*, 1850, p. 341) referring to a boy, æt. 6 years, with a similar scrotal displacement. 2. Bonnain's case (*L'Union Med.*, 1854, p. 223) of the same kind. 3. Heyenberg's case (Stromeyer's *Handbuch der Chirurgie*, vol. ii, p. 774) referring to a boy, æt. 4½ years, in whom the penis was dislocated beyond the scrotum by a horse's kick, the reduction being successfully performed on the tenth day. 4. Moldenhauser's case (*Berliner klinische Wochenschrift*, No 45, 1874) of a hypogastric luxation in a man æt. 57 years.—*Khirurgitchesky Vestnik*, Oct. Nov. and Dec. 1889, pp. 697–702.

III. Case of Urethro-Femoral Fistule. By Dr. NIKOLAI V. SOLONIKA (Tiflis). The author details the following probably yet unique case: The patient, æt. 29 years, was addmitted to the local Military Hospital on account of a urinary fistula on the right thigh. According

to his statement, two and one half years previously he had been shot from a rifle, the bullet passing through his left buttock near the iliac crest to emerge from the lower segment of the right buttock. For some time he was suffering from agonizing pain about the perineum and pubic bone close to the root of the penis, while for nine months all his urine escaped from the anus during defecations. About one and one-half years before the admission, the urine began to flow, but with difficulty, through the urethra, but shortly afterwards there developed a painful abscess on the thigh which was subsequently incised, a large quantity of pus with two pieces of dead bone escaping. The incision never healed but became transformed into a permanent fistule, through which all his urine passed ever since. In order to prevent contraction of the sinus, the patient was constantly wearing a piece of a drainage tube inserted into the opening and tied around the thigh. The micturition was always quite voluntary, the "calls" being preserved, but rather frequent and mostly painful. Defecation was quite infrequent. On examination the fistula was found to be situated on the antero-internal aspect of the thigh, a hand's breadth below the Poupartian ligament. A bougie could penetrate only 7 cm. the fistula track being obviously tortuous. The urethra proved to be absolutely impermeable about its membranous division. The perineum was indurated and infiltrated all through (especially about the raphe). A forefinger introduced into the rectum could detect a fairly extensive depressed scar on the anterior wall of the bowel. An external urethrotomy, as the only operative procedure for radical cure, was proposed by Dr. Solonika, but declined by the patient. The author points out that the bullet had evidently wounded both the rectum and urethra, but left intact the bladder with its sphincter.—*Khirurgitchesky Vestnik*, April and May, 1889, p. 311.

VALERIUS IDELSON (Berne).

IV. Absorption of a Piece of Celluloid Catheter by the Bladder. By F. SALTZMANN. A celluloid catheter introduced into the bladder of a patient broke off near the eye and the fragment remained in the bladder. Two years later, a post mortem being made upon the same patient, the bladder was found empty. The fragment of

the catheter had, hence, been absorbed.—*Finska Lokaresallsk handl.* bd. 30, p. 491.

F. H. PRITCHARD (Boston).

V. Treatment of Injuries to the Urethra and Their Sequelæ. By Dr. C. HAGLER. His observations are based upon the experiences in the Basel clinic (Socin's). He discusses the interesting subject of suture of the urethra, both that following primary opening of the perineum and urethra for injury, as well as the resection of a portion of the urethra for stricture resulting from traumatism. In both instances the advantages of the urethral suture were manifest, the parts smoothly uniting, mostly by primary intention and without narrowing. The absence of stricture is accounted for by the fact that the formation of granulation material between the ends of the divided urethra was prevented. Experiments upon dogs confirmed this result. The suture material preferred by Hagler is catgut. In the case heretofore operated upon, the entire thickness of the urethra was included in the suture, but Hagler suggests, in order to avoid premature loosening of the latter, that the mucous urethral membrane be not included (submucous suture). To avoid possible urinary infiltration, the perineal wound should not be closed. In Hagler's experience there is less to be feared from allowing a catheter to remain in situ for the first few days than from repeated catheterization.—*Deutsch. Zeitschrift f. Chir.*, bd., xxix, p. 277.

VI. Upon the Dangers Attending Catheterization in Certain Forms of Retention. By Dr. J. ASSMUTH. That certain risks attend the complete emptying of an over-filled and atonic bladder at one sitting in old individuals suffering from urinary retention has long been a recognized fact. The question as to how far one may venture to unload the viscus naturally arises. Even in special works upon the subject, but an unsatisfactory answer, at best, is given. The dictum that in old persons with overfilled bladders catheterization should not be resorted to, as a rule, is laid down, and still more imperatively should this be insisted upon where the tension upon the bladder has occurred gradually, perhaps occupying years in reaching

this condition. The author's experience, as shown by cases occurring in his own practice, convinces him of the disadvantages of the use of the catheter under these circumstances. Suddenly produced changes of intra vesical pressure bring about a disastrous issue through rapid urinary resorption. He advises that catheterization be employed only when an acute retention supervenes; otherwise the interference should be restricted to the introduction, from time to time, into the bladder, of a full-sized metallic sound. This procedure proved itself useful in retention depending upon different causes, such as prostatic hypertrophy, paraplegia, etc. Patients learn, in the course of time, to urinate voluntarily, the urine approaches its normal condition, and the irritability of the viscus is markedly lessened. Only after a long persistence of the treatment by the sound, and its further use being deemed necessary, should the catheter come into play; and even then its full employment should not be reached until after many sittings, at the same time partially replacing the evacuated urine by means of injected fluid. Although in this class of cases there will occasionally occur those who will tolerate the rapid evacuation of the bladder, yet there is no means of differentiating them beforehand.—*St. Petersburger Med. Wochenschrift.—Centbl. f. Chir.*, 1890, No. 6.

GEORGE R. FOWLER (Brooklyn).

BONES, JOINTS, ORTHOPÆDIC.

I. Two Cases of Bilateral Ankylosis of the Hip-Joint. By E. S. PERMANN.

1. A boy, æt. 12 years, was received August 3, 1888, in the hospital. Two years before he had passed through an osteomyelitis which left behind it a very faulty position of both hip joints. The left thigh was flexed and adducted; the greater trochanter surrounded by cicatrices was about 3½ ins. above the line of Nélaton. The left hip-joint, as well as the knee, which stood at an angle of 45°, were immoveable. The ankle joint was somewhat moveable. The right thigh, flexed, abducted and rotated outward, stood at an angle, open outward, of 70° to the buttocks. The hip immovable, the knee unankylotic, cannot be extended beyond a right angle. The ankle joint moveable. There